Wade-Taxter, Megan (ISDH)

From: Becker, Angela
Sent: Wednesday, September 19, 2018 2:33 PM
To: Wade-Taxter, Megan (ISDH)
Subject: FW: ISDH Public Records Request May 15, 2018
Attachments: 20180808094348502.pdf

-----Original Message-----
From: Becker, Angela
Sent: Wednesday, August 08, 2018 9:54 AM
To: Humbarger, Cathie <Cathie.Humbarger@Ichooselife.org>
Subject: ISDH Public Records Request May 15, 2018

Good morning Ms. Humbarger.

Pursuant to your public records request dated May 15, 2018, the Indiana State Department of Health has attached copies of the most recent abortion facility surveys for all abortion facilities operating in the state.

Kind Regards,

ANGELA L. BECKER
Litigation Liaison & Public Records Coordinator
Office of Legal Affairs
Indiana State Department of Health
317.232.3119 office
317.234.6278 fax
abecker2@isdh.in.gov
www.StateHealth.in.gov

Indiana Life

May 15, 2018

Randall Snyder
Division Director, Acute Care
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Dear Mr. Snyder,

I am requesting copies of the most recent abortion facility surveys for all abortion facilities operating in the state including the locations listed below.

Planned Parenthood of Indiana & Kentucky, 8645 Connecticut St., Merrillville, IN
Planned Parenthood of Indiana & Kentucky, 421 S. College Ave, Bloomington, IN
Planned Parenthood of Indiana & Kentucky, 964 Mezzanine Dr., Lafayette, IN
Planned Parenthood of Indiana & Kentucky, 8590 Georgetown Rd., Indianapolis, IN
Clinic for Women 3607 W. 16th St., Suite 2B, Indianapolis, IN
Women's Med Group, 1201 N. Arlington Ave., Indianapolis, IN

Please send to the address below or e-mail to cathie.humbarger@ichooselife.org
Mail to:
Cathie Humbarger, VP
Indiana Right to Life
2126 Inwood Drive
Fort Wayne, IN 46815

Please let me know of any cost related to this request and I will remit payment immediately.

As always, thank you for your assistance.

Sincerely,

Cathie Humbarger

Cathie Humbarger
Vice President of Media & Strategic Development
Indiana Right to Life

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011133	A. BUILDING: _____ B. WING _____	04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINIC FOR WOMEN	3607 W 16TH ST STE 2B INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	INITIAL COMMENTS This visit was for a State licensure survey. Dates of survey: 4/2/18 to 4/3/18 Facility #0111133 Clinic For Women is in compliance with 410 IAC 26-4 through 410 IAC 26-18, Abortion Clinic Licensure Rules. QA: 4/5/18	T 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011117	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	421 S COLLEGE AVE BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	INITIAL COMMENTS This visit was for a State licensure survey. Dates of survey: 3/14/18 to 3/15/18 Facility #011117 QA: 3/21/18	T 000		
T 026	410 IAC 26-4-1 GOVERNING BODY 410 IAC 26-4-1(c)(3) (c) The governing body shall do the following: (3) Review, at least every six (6) months, reports of management operations, including, but not limited to, the following: (A) Quality assessment and improvement program. (B) Patient services provided. (C) Results attained. (D) Recommendations made. (E) Actions taken. (F) Follow-up. This RULE is not met as evidenced by: Based on document review and interview, the governing body (GB) failed to review quality assessment and performance improvement (QAPI) program reports at least every 6 months during 4 quarters of calendar year 2017. Findings include: 1. Review of GB Board Meeting minutes dated	T 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011117	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	421 S COLLEGE AVE BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 026	Continued From page 1 11/28/2017, 8/26/2017, 5/31/2017, 3/22//2017 and 1/25/2017 lacked documentation of review of QAPI reports by the GB. 2. On 3/15/18 at approximately 3:00pm, A1, Vice President of Patient Services, indicated review of QAPI program reports did not show in GB meeting minutes and the facility had no other documentation of the GB having reviewed QAPI reports within the 4 quarters of the 2017 calendar year.	T 026		
T 118	410 IAC 26-7-1 MEDICAL RECORDS 410 IAC 26-7-1(b)(3) (b) A medical record must be maintained with documentation of service rendered for each surgical abortion patient of the clinic as follows: (3) The clinic shall use a system of author identification and record maintenance that: (A) ensures the integrity of the authentication; and (B) protects the security of all record entries. Each entry must be authenticated in accordance with the clinic and medical staff policies. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to follow their policy/procedure for medical record documentation for 20 of 30 closed medical records (MR) reviewed. Findings:	T 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011117	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	421 S COLLEGE AVE BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 118	Continued From page 2 1. Policy/procedure 5.2, Administrative Chapter 5: Medical Records, Documentation, and Reporting Requirements, revised/reapproved 3/2017 indicated on page 3-4: "III. Documentation must be performed in accordance with accepted professional standards and any applicable laws/regulations. It must...F. Be signed with the full name of the signer including credentials for licensed staff and titles for non-licensed staff". 2. Review of patient 1's MR lacked documentation of authentification signature of medical staff D1 for Visit Summary note dated 3/8/18 at 0750 hours. 3. Review of patient 2's MR lacked documentation of authentification signature of medical staff D1 for Visit Summary note dated 3/8/18 at 0740 hours. 4. Review of patient 3's MR lacked documentation of authentification signature of medical staff D1 for Visit Summary note dated 3/8/18 at 0940 hours. 5. Review of patient 4's MR lacked documentation of authentification signature of medical staff D1 for Visit Summary note dated 2/22/18 at 0730 hours. 6. Review of patient 5's MR lacked documentation of authentification signature of medical staff D1 for Visit Summary note dated 2/22/18 at 0900 hours. 7. Review of patient 6's MR lacked documentation of authentification signature of medical staff D1 for Visit Summary note dated 2/08/18 at 0820 hours.	T 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011117	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	421 S COLLEGE AVE BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 118	Continued From page 3 8. Review of patient 7's MR lacked documentation of authentification signature of medical staff D1 for Visit Summary note dated 2/08/18 at 1000 hours. 9. Review of patient 9's MR lacked documentation of authentification signature of medical staff D1 for Visit Summary note dated 2/01/18 at 1000 hours. 10. Review of patient 10's MR lacked documentation of authentification signature of medical staff D1 for Visit Summary note dated 1/25/18 at 1000 hours. 11. Review of patient 14's MR lacked documentation of authentification signature of medical staff D1 for Visit Summary note dated 12/14/17 at 1330 hours. 12. Review of patient 16's MR lacked documentation of authentification signature of medical staff D1 for Visit Summary note dated 12/07/17 at 1330 hours. 13. Review of patient 17's MR lacked documentation of authentification signature of medical staff D1 for Visit Summary note dated 11/30/17 at 0730 hours. 14. Review of patient 18's MR lacked documentation of authentification signature of medical staff D1 for Visit Summary note dated 11/16/17 at 1230 hours. 15. Review of patient 19's MR lacked documentation of authentification signature of medical staff D1 for Visit Summary note dated 09/21/17 at 1028 hours.	T 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011117	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	421 S COLLEGE AVE BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 118	Continued From page 4 16. Review of patient 20's MR lacked documentation of authentification signature of medical staff D1 for Visit Summary note dated 08/31/17 at 0822 hours. 17. Review of patient 21's MR lacked documentation of authentification signature of medical staff D1 for Visit Summary note dated 08/24/17 at 1120 hours. 18. Review of patient 22's MR lacked documentation of authentification signature of medical staff D1 for Visit Summary note dated 08/10/17 at 1033 hours. 19. Review of patient 28's MR lacked documentation of authentification signature of medical staff D1 for Visit Summary note dated 04/20/17 at 0820 hours. 20. Review of patient 29's MR lacked documentation of authentification signature of medical staff D1 for Visit Summary note dated 04/12/17 at 1410 hours. 21. Review of patient 30's MR lacked documentation of authentification signature of medical staff D1 for Visit Summary note dated 03/30/17 at 0842 hours 22. On 3/15/18 at approximately 1200 hours, staff N1 (Director of Clinical Operations) was interviewed and confirmed patient 1, 2, 3, 4, 5, 6, 7, 9, 10, 14, 16, 17, 18, 19, 20, 21, 22, 28, 29 and 30's MR lacked documentation of a medical staff provider's signature and confirmed the medical staff provider is required to authenticate medical record documentation per his/her signature. Staff N1 confirmed staff should follow policy/procedure for medical records documentation.	T 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011117	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	421 S COLLEGE AVE BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 184	410 IAC 26-10-1 PATIENT CARE AND NURSING SERVICES 410 IAC 26-10-1(a)(1) (a) All patient care services must: (1) meet the needs of the patient, within the scope of the service offered, in accordance with acceptable standards of practice; This RULE is not met as evidenced by: Based on document review and interview, the facility failed to follow their policy/procedure for recovery area assessment criteria for 6 of 22 closed medical records (MR) reviewed. Findings: 1. Policy/procedure 18.1.2, Recovery Area Assessment Criteria, revised/reapproved 6/2016 indicated on page 2 indicated: "1. A. Patients receiving minimal or no sedation who are post surgical abortion....must assess the following at initiation of recovery and then at least every 15 minutes during the recovery process until discharge. Blood pressure, respiratory rate, pulse (a minimum of 2 sets)." 2. Review of patient 5, 6, 7, 18, 19 and 22's MR lacked documentation of assessment of 2 complete sets of vital signs to include blood pressure, respiratory rate and pulse at initiation of recovery. 3. On 3/14/18 at approximately 1430 hours, staff N1 (Director of Clinical Operations) was interviewed and confirmed patient 5, 6, 7, 18, 19 and 22's MR lacked documentation of	T 184		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011117	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	421 S COLLEGE AVE BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 184	Continued From page 6 assessment of 2 complete sets of vital signs to include blood pressure, respiratory rate and pulse. Staff N1 confirmed staff failed to complete assessment at initiation of recovery as written per facility policy.	T 184		
T 206	410 IAC 26-11-1 INFECTION CONTROL PROGRAM 410 IAC 26-11-1(a)(1) (a) The clinic must do the following: (1) Provide a safe and healthful environment that minimizes infection exposure and risk to the following: (A) Patients. (B) Health care workers. (C) Persons who accompany patients. This RULE is not met as evidenced by: Based on document review, observation and interview the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients and health care workers for 1 of 3 (Lab) areas toured. Findings include: 1. Review of PPINK (Planned Parenthood Indiana Kentucky) Infection Control Manual &OSHA Risk Exposure Plan, revised/reviewed 04/2017 indicated: A. page 19: "Standard precautions are OSHA's required method of control to protect staff from exposure to all human blood, certain human body fluids and other potentially infectious material (OPIM). In using Standard Precautions,	T 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011117	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	421 S COLLEGE AVE BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 206	Continued From page 7 we assume that all human blood and OPIM be treated as if known to be infectious for hepatitis B virus, HIV, or other blood borne pathogens regardless of the perceived "low risk" of a patient. In the health care setting, standard precautions apply to all patients regardless if you suspect or do not suspect they may be contagious". B. page 20: "Soiled patient care equipment: Handle in a manner that prevents transfer of microorganisms to others and to the environment". 2. While on tour of facility on 3/15/18 at approximately 1400 hours, accompanied by staff N2 (Center Manager), 4 bottles of medications including 1 bottle of Ibuprofen 800 mg 100 tablets, 1 bottle of metronidazole 500 mg 50 tablets and 2 bottles of azithrozycin 250 mg 30 tablets, were found on the countertop in the lab room along with supplies for specimen processing of labs including Rh and pregnancy testing. 3. Staff N2 (Center Manager) was interviewed on 3/15/18 at approximately 1415 hours and confirmed staff set the above-mentioned medication bottles on the countertop for easy access to administer to patients. Staff N2 confirmed the countertop is also used as workspace for processing lab specimens including urine and blood for Rh and pregnancy testing. Staff N2 confirmed staff should observe standard precautions. Staff N2 confirmed processing lab specimens utilizing urine and blood samples on the same countertop which patient medications are placed may result in exposure to potentially infectious material.	T 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011117	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	421 S COLLEGE AVE BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 214	Continued From page 8	T 214		
T 214	410 IAC 26-11-1 INFECTION CONTROL PROGRAM 410 IAC 26-11-1(c) (c) The clinic must designate a person qualified by training or experience as responsible for the following: (1) Ongoing infection control activities. (2) The development and implementation of policies governing control of infections and communicable diseases. This RULE is not met as evidenced by: Based on document interview the facility failed to designate a person qualified by training or experience as responsible for facility infection control activities. Findings include: 1. Staff N3 (Director of Clinical Services) was interviewed on 3/15/18 at approximately 1300 hours and confirmed the facility did not have a person designated responsible for facility infection control activities.	T 214		
T 232	410 IAC 26-11-1 INFECTION CONTROL PROGRAM 410 IAC 26-11-1(e)(2)(E) (e) The clinic must establish a committee to monitor and guide the infection control program in the clinic as follows: (2) The infection control committee responsibilities must include, but are not limited	T 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011117	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	421 S COLLEGE AVE BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 232	Continued From page 9 to, the following: (E) Reviewing and recommending changes in procedures, policies, and programs that are pertinent to infection control. These include, but are not limited to, the following: (i) Sanitation, including proper disposal of removed tissue. (ii) Universal precautions, including infectious waste management. (iii) Cleaning, disinfection, and sterilization. (iv) Aseptic technique, invasive procedures, and equipment usage. (v) Reuse of disposables. (vi) A system for handling patients with communicable diseases. (vii) A system, which complies with state and federal law, to monitor the immune status of health care workers exposed to communicable diseases. (viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies. (ix) Requirements for personal hygiene and attire that meet acceptable standards of practice. (x) A program of linen management. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to follow the facility's infection control	T 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011117	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	421 S COLLEGE AVE BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 232	Continued From page 10 policies and procedures (P&P) for housekeeping services for 5 of 7 personnel files reviewed (S1, S2, S3, S4 and S6). Findings include: 1. Review of facility policies and procedures of the Infection Control Manual & OSHA (Occupational Safety and Health Administration) Risk Exposure Plan, Revised 04/2017, indicated the following: Housekeeping Services. In all health centers daily cleaning and decontamination of the exam rooms, labs and equipment is done by trained staff... 2. Review of personnel files for S1, S2, S3, S4 and S6 lacked documentation of daily cleaning and decontamination training. 3. On 3/15/18 at approximately 2:00pm, A1, Vice President of Patient Services, indicated that the contracted housekeeping service did not clean or decontaminate exam rooms, laboratories or equipment. A1 further indicated that those processes are performed by staff members and that any staff member, including S1, S2, S3, S4, S5, S6 and S7, could perform those duties. A1 verified lack of documentation of housekeeping/cleaning and decontamination training for S1, S2, S3, S4 and S6 and indicated that S5, date of hire 11/6/17, was still in orientation.	T 232		
T 322	410 IAC 26-16-1 PHARMECEUTICAL SERVICES 410 IAC 26-16-1(3)(A) The clinic must provide drugs and biologicals in a	T 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011117	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	421 S COLLEGE AVE BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 322	Continued From page 11 safe and effective manner in accordance with accepted professional practice. The clinic must have the following: (3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following: (A) Drug: (i) handling; (ii) storing; (iii) labeling; (iv) dispensing; and (v) administration according to established clinic policies and acceptable standards of practice. This RULE is not met as evidenced by: Based on document review, observation and interview, the facility failed to follow its policy/procedure for expired medications & unauthorized access to medications for 1 facility. Findings include: 1. Review of policy/procedure PS_15, Pharmaceuticals in the Health Centers, revised/reviewed 2/15/18 indicated the following: All medications, except controlled substances, will be stored in locked areas away from patient access; only licensed staff may access medications unless under the direct supervision of a licensed provider. All expired medication must be tracked on the Expired Medication Log - the log is available on	T 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011117	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	421 S COLLEGE AVE BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 322	Continued From page 12	T 322		

the Health Center Resources Drive; expired medications should be disposed of immediately in each health center's expired medication bin; this must be stored in a locked area away from patient access.

2. On 3/15/18 between 11:00am and 12:00pm, during facility tour, in the presence of A6, Facility Manager, in room #8, the recovery room, inside the medication storage refrigerator were 2 vials Promethazine 25mg/ml observed with a manufacturer expiration date of 10/2017.

3. On 3/15/18 at approximately 11:45am, A6 indicated the expired Promethazine should have been discarded and should not be in the patient medication refrigerator.

4. While on tour of facility on 3/15/18 at approximately 1400 hours, accompanied by staff N2 (Center Manager), 4 bottles of medications including 1 bottle of Ibuprofen 800 mg 100 tablets, 1 bottle of metronidazole 500 mg 50 tablets and 2 bottles of azithrozycin 250 mg 30 tablets, were found unsecured located on the countertop in the lab room.

5. While on tour of facility on 3/15/18 at approximately 1430 hours, accompanied by staff N2, a medication refrigerator was observed to be unlocked and contained medications for patient administration that unauthorized individuals could have access to.

6. Staff N2 (Center Manager) was interviewed on 3/15/18 at approximately 1430 hours and confirmed staff placed the above-mentioned medication bottles on the countertop in the lab room for ease of access to administer to patients. Staff N2 confirmed the medications located on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011117	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	421 S COLLEGE AVE BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 322	Continued From page 13 the countertop of the lab room were unsecured and potentially accessible to unauthorized individuals. Staff N2 confirmed the medication refrigerator located in the recovery area was unlocked and contained medications for administration to patients.	T 322		
T 404	410 IAC 26-17-3 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-3(2) The condition of the physical plant and the overall clinic environment must be developed and maintained in such a manner that the safety and well-being of patients is assured as follows: (2) No condition may be created or maintained that may result in a hazard to: (A) patients; (B) authorized visitors; or (C) employees. This RULE is not met as evidenced by: Based on observation and interview, the facility created a condition that may have resulted in a hazard to patients, visitors or employees in 1 instance for 1 facility. Findings include: 1. On 3/15/18 at approximately 12:00pm, during facility tour, in the presence of A6, Facility Manager, and A1, Vice President of Patient Services, the following was observed: In an office (indicated to be the area of medical gas storage), on the floor, leaned up against a desk was an	T 404		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011117	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	421 S COLLEGE AVE BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 404	Continued From page 14 unsecured green oxygen cylinder tank. 2. On 3/15/18 at approximately 12:00pm, A1 verified that the oxygen tank was unsecured, could create a source of potential hazard to patients, visitors or employees and should be stored in a secured manner and location.	T 404		
T 414	410 IAC 26-17-4 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-4(1) All patient care equipment must be in good working order and regularly serviced and maintained as follows: (1) All patient care equipment must be on a documented maintenance schedule of appropriate frequency in accordance with one (1) of the following: (A) Acceptable standards of practice. (B) The manufacturer ' s recommended maintenance schedule. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure 6 of 8 pieces/types of patient care equipment (defibrillator, emergency call system, recovery chairs, vacuum units, examine tables, and procedure tables) were on a documented maintenance schedule in accordance with acceptable standards or the manufacturer's recommendations. Findings include:	T 414		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011117	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	421 S COLLEGE AVE BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 414	Continued From page 15	T 414		

1. Review of the policy titled Equipment Maintenance, March 24, 2017 (review/revise/approve/effective not noted), indicated the following: Ensure that required inspections, testing and maintenance is performed in accordance with the required Federal and State laws, regulations, guidelines, standards and manufacturer's recommendations.

2, Review of the manufacturer manual recommendations for maintenance indicated the following:

A. Zoll AED Plus Defibrillator/AED (automated external defibrillator): Inspect frequently, as necessary. Use the following maintenance checklist when you periodically check your AED. Check the following: (included, but was not limited to) Is the unit clean, undamaged, free of excessive wear? Are there any crack or loose parts? Batteries within expiration date. Replace if expired.

B. No manuals for the emergency call code system or exam lights were provided. Unable to determine manufacturer recommendations or acceptable standards.

C. Champion "Passage" Recliner/recovery room chairs: General Maintenance and Care of Chairs, included the following: Periodically, check that the hinge fasteners, latch mount, release mount and back mount fasteners are secure. We suggest monthly, then tailor to our (sic) findings.

D. Cabot Medical, Berkley Vacuum Curettage System: Maintenance. Check the float ball mechanism within the safety trap periodically. Replace filter when it becomes soiled or clogged.

E. Midmark Ritter, exam table(s): Preventive Maintenance: Periodically inspect the following areas: Power cord. All fasteners. All mechanical functions. Periodically lubricate the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011117	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	421 S COLLEGE AVE BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 414	Continued From page 16 Back hinge. Footrest slide. Have an authorized service technician inspect your table every six month. F. Midmark Universal Procedures Table Procedure table: Scheduled Maintenance: Interval: Weekly: Visually inspect components for damage. Semi-Annually: Check all mechanical functions. Table shrouds should move smoothly. Replace any missing or illegible labels. All fasteners must be present and fastened securely. Inspect power cord and all wiring. Be sure all electrical connections are tight. 3. Review of preventive maintenance (PM) documentation indicated the following for patient care equipment as follows: A. Defibrillator/AED: Maintenance Checks logs lacked documentation of what was checked or done. Unable to determine checks/maintenance was in accordance with manufacturer recommendations. B. Emergency call code system: Maintenance check logs indicated the following: Date Performed, 11/19 (2017), "Telephone Intercom System", "IT working on them". Date Performed 3/5/18, "Telephone Intercom System" - "Does not work". C. Biomedical engineering and internal PM documents lacked documentation of PM on the recliners/recovery room chairs. D. Biomedical engineering document dated 5/2/17, titled Annual Equipment Maintenance lacked documentation of PM for vacuum unit(s). Document of PM for a suction unit lacked documentation of what tasks were performed. Internal Equipment Maintenance Check logs lacked documentation of vacuum unit(s), listed Suction Machines, but lacked documentation of what tasks/checks were performed.	T 414		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011117	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	421 S COLLEGE AVE BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 414	Continued From page 17 E. Biomedical engineering document dated 5/2/17, titled Annual Equipment Maintenance lacked documentation of every 6 month PM and lacked documentation of tasks performed for PM of exam tables. F. Biomedical engineering document dated 5/2/17, titled Annual Equipment Maintenance lacked documentation of PM for procedure table(s). Internal Maintenance check logs lacked documentation of PM for procedure table(s). 4. A. On 3/14/18 between approximately 12:45pm and 2:00pm, the following was indicated in interview: A1, Vice President of Patient Services, indicated the clinic utilized a phone system as the emergency call code system. B. On 3/15/18 between approximately 12:30pm and 2:00pm, the following was indicated in interview: A3, Director of Clinical Operations, indicated any PM done on equipment in the clinic would be documented on the biomedical engineering form titled Annual Equipment Maintenance or the internal form titled Equipment Maintenance Checks. A3 verified that the forms lacked documentation of PM tasks were performed.	T 414		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011118	A. BUILDING: _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	8590 GEORGETOWN RD INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	INITIAL COMMENTS This visit was for a state licensure survey. Facility Number: 011118 Survey Date: 03-27-2018 to 03-28-2018 QA: 4/02/2018	T 000		
T 004	410 IAC 26-2-7 LICENSE REQUIREMENTS 410 IAC 26-2-7 A license issued under this article must be conspicuously posted on the premises in an area open to patients. This RULE is not met as evidenced by: Based on observation, the facility failed to conspicuously post a current license for 1 facility. Findings include: 1. On 03-27-2018 at 2:50 pm. in the presence of employee #A2, Vice President of Patient Services, and employee #A5, Health Center Manager, it was observed in the waiting room area there was not a current license posted. The license posted was observed to have an expiration date of 06-30-2017.	T 004		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011118	A. BUILDING: _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	8590 GEORGETOWN RD INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 134	Continued From page 1	T 134		
T 134	410 IAC 26-7-2 MEDICAL RECORDS 410 IAC 26-7-2(c) (c) Patient records for surgical abortions must document and contain, at a minimum, the following: (1) Patient identification. (2) Appropriate medical history. (3) Results of the following: (A) A physical examination. (B) Diagnostic or laboratory studies, or both (if performed). (4) Any allergies and abnormal drug reactions. (5) Entries related to anesthesia administration. (6) Evidence of appropriate informed consent for procedures and treatments as required by IC 16-34-2- 1.1. (7) A report describing techniques, findings, and tissue removed or altered. (8) Authentication of entries by the physician or physicians and health care workers who treated or cared for the patient. (9) Condition on discharge, disposition of the patient, and time of discharge. (10) Discharge entry to include instructions to the patient or patient ' s legal representative. (11) A copy of the following: (A) The transfer form if the patient was referred to a hospital or other facility. (B) The terminated pregnancy report filed with the department. (12) Any report filed with a state agency or law enforcement agency pursuant to a statutory reporting requirement.	T 134		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011118	A. BUILDING: _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	8590 GEORGETOWN RD INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 134	Continued From page 2 This RULE is not met as evidenced by: Based on document review and interview, one (1) of thirty (30) medical records reviewed lacked documentation of appropriate informed consent for procedures and treatments as required by IC 16-34-2-1.1. 1. PPINK Administrative Chapter 4: Consent, Informed Consent and Patient Education, last revised 6/2016, indicated: The informed consent process must take place. It is the professional and legal duty of every affiliate to provide each patient with adequate information regarding the nature of the proposed services. 2. Medical record #30 lacked documentation of a signed abortion informed consent certification, State Form 55320. 3. Staff member #O4 indicated in interview on 3/28/2018 at 1000 hours, that the medical record #30 lacked documentation of the required form. He/she also indicated that since the forms are scanned into the EMR, that it may not have gotten scanned in.	T 134		
T 144	410 IAC 26-8-1 PERSONNEL POLICIES AND RECORDS 410 IAC 26-8-1(c)(1) (c) The clinic must do the following: (1) Maintain current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on the job	T 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011118	A. BUILDING: _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	8590 GEORGETOWN RD INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 144	Continued From page 3 description, for each employee and contract and agency personnel. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to follow its policy to conduct an annual evaluation on 1 of 4 employees files reviewed. Findings include: 1. Review of the Employee Handbook, approved February 2015, indicated employees may receive an annual performance evaluation. 2. Review of 4 employee personnel files indicated file P4, Nurse Practitioner, did not have any documentation of a current annual evaluation. 3. In interview on 03-28-2018 at 10:30 am, employee #A2, Vice President Patient Services, confirmed all the above, including the facility policy was as indicated in the Employee Handbook, and no other documentation was provided prior to exit.	T 144		
T 168	410 IAC 26-8-3 PERSONNEL POLICIES AND RECORDS 410 IAC 26-8-3(b)	T 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011118	A. BUILDING: _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	8590 GEORGETOWN RD INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 168	Continued From page 4 (b) The clinic shall ensure cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and clinic policy for all health care workers including contract and agency personnel who provide direct patient care. This RULE is not met as evidenced by: Based on document review and interview, the clinic failed to ensure that one (1) staff members of ten (10) staff member's personnel files reviewed and 1 of 6 medical staff credential files reviewed, had documented cardiopulmonary resuscitation (CPR) competency per facility policy. Findings include; 1. Review of a facility document titled PPINK 0417, CPR Certification Policy, approved 4/21/2017, indicated the Following; Purpose: All staff participating in patient care must be Basic Life Support (BLS) Cardiopulmonary Resuscitation certified by the American Heart Association. Policy: All staff who are not CPR certified at hire are required to obtain certification prior to beginning patient care. 2. Nursing Personnel #N3's file, healthcare assistant, who was hired 9/5/2017, and does patient care, lacked documentation of CPR training.	T 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011118	A. BUILDING: _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	8590 GEORGETOWN RD INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 168	Continued From page 5 3. Review of medical staff credential files indicated file MD#6 Medical Director, a direct patient care provider, did not have any documentation of current CPR competency, per facility policy. 4. In interview on 3/28/2018 at 1050 hours, employee #A7, Human Resources Generalist, confirmed all the above and no other documentation was provided prior to exit. 5. In interview on 3/28/2018 at 1200 hours, staff member #O5, Human Resources, indicated agreement with the finding that staff #N3's personnel file lacked documentation of CPR training.	T 168		
T 206	410 IAC 26-11-1 INFECTION CONTROL PROGRAM 410 IAC 26-11-1(a)(1) (a) The clinic must do the following: (1) Provide a safe and healthful environment that minimizes infection exposure and risk to the following: (A) Patients. (B) Health care workers. (C) Persons who accompany patients. This RULE is not met as evidenced by: Based on observation, document review and interview, the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk in 1 instance. Findings include:	T 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011118	A. BUILDING: _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	8590 GEORGETOWN RD INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 206	Continued From page 6 1. On 03-27-2018 at 3:25 pm in the presence of employee #A2, Vice President of Patient Services, employee #A5, Health Center Manager, and employee #A6, Health Care Assistant, it was observed in an ultrasound room there were test strips being used to determine the effectiveness of Cidex, a chemical agent being used to disinfect probes for ultrasound procedures. 2. Review of the manufacturer's recommendation on the insert package of instructions for Quality Control Procedures of the test strip bottle indicated testing of positive and negative controls must be performed on each newly opened bottle of CIDEX OPA Solution. 3. On the above date and time, employee #A6 was requested to provide documentation of following the above-stated Quality Control Procedures. The employee indicated there was no such documentation because the Quality Control Procedures were not performed, and no other documentation was provided prior to exit.	T 206		
T 320	410 IAC 26-16-1 PHARMACEUTICAL SERVICES 410 IAC 26-16-1(2) The clinic must provide drugs and biologicals in a safe and effective manner in accordance with accepted professional practice. The clinic must have the following: (2) Records of stock supplies of all scheduled substances, including an accounting for all items purchased and dispensed.	T 320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011118	A. BUILDING: _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	8590 GEORGETOWN RD INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 320	Continued From page 7 This RULE is not met as evidenced by: Based on document review and interview, the facility failed to follow its policy for accounting of scheduled substances in 67 of 90 instances, and failed to document the Medical Director Review of the log used for the accounting in 9 of 9 instances. Findings include: 1. Review of facility policy titled Health Center Logs, REFERENCE CODE: PS04, approved 11-29-2017 indicated staff must follow the instructions on each log. 2. Review of 9 facility documents titled CONTROL SUBSTANCE LOG, dated 1/31/18 through 3/4/18, indicated the following: Instructions: Must be completed every procedure day by 2 staff members (2 licensed staff members, 1 licensed staff member and the health center manager or assistant manager) for all control substances. An unlicensed staff member may only complete the count if a licensed staff member, Health Center Manager, or Assistant Manager is not on site. Provider and Health Center Manager should review log monthly and document review by signing and dating below. 3. Further review of the 9 facility documents titled CONTROL SUBSTANCE LOG indicated: 90 daily entries - 23 were initialed by 2 licensed staff members and 67 were initialed by only 1 licensed staff member 9 log pages were not signed indicating the Provider had reviewed.	T 320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011118	A. BUILDING: _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	8590 GEORGETOWN RD INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 320	Continued From page 8 4. In interview on 03-27-2018 at 2:35 pm, employee #A2, Vice President of Patient Services, confirmed all the above and no other documentation was provided by exit.	T 320		
T 404	410 IAC 26-17-3 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-3(2) The condition of the physical plant and the overall clinic environment must be developed and maintained in such a manner that the safety and well-being of patients is assured as follows: (2) No condition may be created or maintained that may result in a hazard to: (A) patients; (B) authorized visitors; or (C) employees. This RULE is not met as evidenced by: Based on observation, the facility created 1 condition that may have resulted in a hazard to patients, authorized visitors, or employees. Findings include: 1. On 03-27-2018 at 3:15 pm in the presence of employee #A2, Vice President of Patient Services, and employee #A5, Health Center Manager, it was observed in the hallway next to a crash cart, there was 1 small oxygen tank unsecured by chain or holder. If the tank was knocked over and broke the head off the compressed cylinder, it could result in harm to	T 404		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011118	A. BUILDING: _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	8590 GEORGETOWN RD INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 404	Continued From page 9 people and/or property.	T 404		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013765	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	964 MEZZANINE DR LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	INITIAL COMMENTS This visit was for a State licensure survey. Facility Number: 013765 Dates of Survey: 3/5/2018 to 3/7/2018 QA: 3/15/2018	T 000		
T 144	410 IAC 26-8-1 PERSONNEL POLICIES AND RECORDS 410 IAC 26-8-1(c)(1) (c) The clinic must do the following: (1) Maintain current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on the job description, for each employee and contract and agency personnel. This RULE is not met as evidenced by: Based on document review and interview the facility failed to provide an annual evaluation of 2 out of 3 eligible employees. 1. Review of the 2015 Planned Parenthood Employee Handbook indicated on page 10 under Performance Evaluations that employees may receive an annual performance evaluation by their immediate supervisor and may be asked to complete a self-evaluation. Evaluations are kept	T 144		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013765	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	964 MEZZANINE DR LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 144	Continued From page 1 in the employee's personnel file. 2. Review of P50, Health Care Manager's job description indicates under Essential Functions: Prepares disciplinary and performance improvement documents independently and provides indicated management follow-up. 3. Review of P50 and P52, Health Care Assistant personnel files lacked documentation of an evaluation completed in 2017 or 2018. 4. Interview with P50 and P58, Director of Clinical Services on 03/06/18 at 3:20 pm confirmed lack of evaluations in P50's and P52's personnel file and they were not done.	T 144		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011116	A. BUILDING: _____ B. WING _____	03/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	8645 CONNECTICUT ST MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	INITIAL COMMENTS This visit was for a State licensure survey. Facility Number: 011116 Dates of Survey: 3/19/2018 to 3/21/2018 Planned Parenthood of Indiana - Merrillville Clinic is in compliance with 410 IAC 26, Abortion Clinic Licensure Rules. QA: 03/23/2018	T 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011128	A. BUILDING: _____ B. WING _____	04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOMEN'S MED GROUP PROFESSIONAL CORPORAT	1201 N ARLINGTON AVE INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	INITIAL COMMENTS This visit was for a state licensure survey. Facility Number: 011128 Survey Date: 04-02-2018 to 04-04-2018 QA: 4/12/18	T 000		
T 098	410 IAC 26-6-1 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 26-6-1(a)(2) The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (2) All functions, including, but not limited to, the following: (A) Discharge. (B) Transfer. (C) Infection control. (D) Response to patient emergencies. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to include response to patient emergencies in its quality assurance and performance improvement program (QAPI) for calendar year 2017. Findings include:	T 098		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011128	A. BUILDING: _____ B. WING _____	04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOMEN'S MED GROUP PROFESSIONAL CORPORAT	1201 N ARLINGTON AVE INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 098	Continued From page 1 1. Review of the clinic's QAPI program for calendar year 2017 indicated it did not include response to patient emergencies 2. In interview on 04-04-2018 at 5:15 pm, employee #A1, Assistant Director, confirmed the above and no other documentation was provided prior to exit.	T 098		
T 134	410 IAC 26-7-2 MEDICAL RECORDS 410 IAC 26-7-2(c) (c) Patient records for surgical abortions must document and contain, at a minimum, the following: (1) Patient identification. (2) Appropriate medical history. (3) Results of the following: (A) A physical examination. (B) Diagnostic or laboratory studies, or both (if performed). (4) Any allergies and abnormal drug reactions. (5) Entries related to anesthesia administration. (6) Evidence of appropriate informed consent for procedures and treatments as required by IC 16-34-2- 1.1. (7) A report describing techniques, findings, and tissue removed or altered. (8) Authentication of entries by the physician or physicians and health care workers who treated or cared for the patient. (9) Condition on discharge, disposition of the patient, and time of discharge. (10) Discharge entry to include instructions to the patient or patient ' s legal representative.	T 134		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011128	A. BUILDING: _____ B. WING _____	04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOMEN'S MED GROUP PROFESSIONAL CORPORAT	1201 N ARLINGTON AVE INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 134	Continued From page 2 (11) A copy of the following: (A) The transfer form if the patient was referred to a hospital or other facility. (B) The terminated pregnancy report filed with the department. (12) Any report filed with a state agency or law enforcement agency pursuant to a statutory reporting requirement. This RULE is not met as evidenced by: Based on document review and interview the facility failed to ensure a copy of the terminated pregnancy report was in the medical record (MR) in 25 of 25 medical records reviewed (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24 and 25). Findings Include: 1. Review of patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24 and 25's medical records lacked documentation of a terminated pregancy report state form 56114. 2. Interview on 4/4/2018, at approximately 12:30 pm with N1 (Registered Nurse, Assistant Director) confirmed facility had not included a state form 56114 in the medical records.	T 134		
T 140	410 IAC 26-8-1 PERSONNEL POLICIES AND RECORDS 410 IAC 26-8-1(a)(2)	T 140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011128	A. BUILDING: _____ B. WING _____	04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOMEN'S MED GROUP PROFESSIONAL CORPORAT	1201 N ARLINGTON AVE INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 140	Continued From page 3 (a) The abortion clinic shall maintain current and accurate personnel records for all employees. Personnel records shall: (2) include personal data to include: (A) education; (B) experience; (C) date of employment; (D) a copy of current license when required; (E) evidence of participation in job-related educational and training activities; and (F) health records of employees that relate to post offer and subsequent: (i) physical examinations; (ii) tests; and (iii) immunizations. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure physical examination for 2 (S1, and S5) personnel files of 6 personnel files reviewed. Finding include: 1. Review of facility policy, Safety, revised 3/1/2018, indicated the following, the record contains the following on each employee, name and social security number, a copy of the hepatitis vaccination series status including dates and information relative to the employee's ability to receive the vaccination, copies of annual immunizations and TB testing or exam, a copy of employee accidents reports, a copy of all occupational examination results, medical testing	T 140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011128	A. BUILDING: _____ B. WING _____	04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOMEN'S MED GROUP PROFESSIONAL CORPORAT	1201 N ARLINGTON AVE INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 140	Continued From page 4 and follow-up procedures, the employer's copy of the healthcare professional's written opinion, a copy of information provided to the healthcare professional, records of occupational exposure monitoring, records of occupational safety training and records of any other occupational medicine intervention. 2. Review of personnel files indicated the following, S1 (Medical Assistant) and S5 (Licensed Practical Nurse), lacked documentation of Physical Examination. 3. Interview on 4/3/2018, at approximately 9:50 am, with N1 (Registered Nurse, Assistant Director) confimed the above.	T 140		
T 168	410 IAC 26-8-3 PERSONNEL POLICIES AND RECORDS 410 IAC 26-8-3(b) (b) The clinic shall ensure cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and clinic policy for all health care workers including contract and agency personnel who provide direct patient care. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to follow its policy to ensure cardiopulmonary resuscitation (CPR) competence in accordance with clinic policy for 1 of 2 physician credential files reviewed and 2 of 6 employee files reviewed.	T 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011128	A. BUILDING: _____ B. WING _____	04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOMEN'S MED GROUP PROFESSIONAL CORPORAT	1201 N ARLINGTON AVE INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 168	Continued From page 5 1. Review of a facility document titled Employee Safety Handbook, approved 03/01/18, indicated the Safety Manager maintains a record of each employee's training in basic CPR and BLS [basic life safety]. Further review of the document indicated the Safety Manager ensures that physicians maintain currency (sic) in Provider ACLS [advanced cardiac life support]. 2. Review of 2 physician credential files indicated file MD#2, Gynecologist, had documentation of ACLS that expired 3/20/2016, not current per facility policy. 3. Review of employee files indicated file S1, Medical Assistant, and S5, Licensed Practical Nurse, lacked documentation of CPR competence per facility policy. 3. In interview on 04-04-2018 at approximately 5:15 pm, employee #A1, Assistant Director, confirmed all the above and no other documentation was provided prior to exit.	T 168		
T 206	410 IAC 26-11-1 INFECTION CONTROL PROGRAM 410 IAC 26-11-1(a)(1) (a) The clinic must do the following: (1) Provide a safe and healthful environment that minimizes infection exposure and risk to the following: (A) Patients. (B) Health care workers. (C) Persons who accompany patients.	T 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011128	A. BUILDING: _____ B. WING _____	04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOMEN'S MED GROUP PROFESSIONAL CORPORAT	1201 N ARLINGTON AVE INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 206	Continued From page 6 This RULE is not met as evidenced by: Based on document review, observation and interview, the facility failed to ensure a safe and healthful environment that minimizes infection exposure and risk in patients in three instances. Findings include: 1. Review of Hemocue Operating Manual indicated the following, the cover may be cleaned with alcohol or a mild soap solution. 2. On observation 4/2/2018, at approximately 2:27 pm with N1 (Registered Nurse, Assistant Director) the following was observed, a cardboard note with brownish colored droplets taped on hemocue cover. 3. Interview on 4/2/2018, at approximately 2:47 pm, with N1, confirmed there was brownish colored droplets on cardboard note taped to hemocue cover. 4. On observation 4/2/2018, at approximately 3:15 pm, with N1 (Registered Nurse, Assistant Director) the following was observed washer and dryer in back of storage room. Floor of room with sticky lines of material (appears to be old flooring glue) which could not be properly cleaned. Dirt and debris under shelves with sterile supplies including, gloves, cytology brushes and cotton tip applicators stored on the shelves. 5. Interview on 4/2/2018, at approximately 3:15 pm with N1, confirmed the dirty laundry was bought into storage room and loaded into machines, the floor was covered in sticky lines and sterile supplies were stored on shelves.	T 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011128	A. BUILDING: _____ B. WING _____	04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOMEN'S MED GROUP PROFESSIONAL CORPORAT	1201 N ARLINGTON AVE INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 206	Continued From page 7 6. Review of facility policy, Women's Med, revised 12/6/2017, indicated the following, Inventory Management, ensures items do not expire before being used. 7. On observation 4/2/2018, at approximately 3:27 pm, with N1 (Registered Nurse, Assistant Director) the following was observed 1 box of 23G needles expired in 2001-08, containing 22 needles. 8. Interview on 4/2/2018, at approximately 3:27 pm with N1, confirmed the expired needles.	T 206		
T 234	410 IAC 26-11-2 INFECTION CONTROL PROGRAM 410 IAC 26-11-2(a) (a) Sterilization of equipment and supplies must be provided, within the scope of the service offered, in accordance with acceptable standards of practice or manufacturer ' s recommendations and applicable state laws and rules (to include 410 IAC 1-4, Universal Precautions). This RULE is not met as evidenced by: Based on document review, interview and observation, the facility failed to ensure facility policy was followed regarding cleaning of instruments in one facility. Findings include:	T 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011128	A. BUILDING: _____ B. WING _____	04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOMEN'S MED GROUP PROFESSIONAL CORPORAT	1201 N ARLINGTON AVE INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 234	Continued From page 8 1. Review of facility policy, Safety, revised 3/1/2017, indicated the following, immerse instruments in a enzymatic cleaner/lubricant (such as Metri Clean) for 5 minutes following the manufacturer's directions for preparation and use. 2. Observation on 4/2/2018, at approximately 4:25 pm with N1 (Registered Nurse, Assistant Director) the following was observed. Metri Clean 2 in instrument processing area. Review of the Metri Clean 2 label indicated it was not an enzymatic cleaner. 3. Interview with on 4/2/2018, at approximately 4:25 pm, with N2 (Medical Assistant) confirmed Metri Clean 2 was used to clean instruments. 4. Interview on 4/2/2018, at approximately 4:34 pm, with N1 confirmed Metri Clean 2 instrument cleaner was not enzymatic.	T 234		
T 322	410 IAC 26-16-1 PHARMECEUTICAL SERVICES 410 IAC 26-16-1(3)(A) The clinic must provide drugs and biologicals in a safe and effective manner in accordance with accepted professional practice. The clinic must have the following: (3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following: (A) Drug: (i) handling; (ii) storing;	T 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011128	A. BUILDING: _____ B. WING _____	04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOMEN'S MED GROUP PROFESSIONAL CORPORAT	1201 N ARLINGTON AVE INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 322	Continued From page 9 (iii) labeling; (iv) dispensing; and (v) administration according to established clinic policies and acceptable standards of practice. This RULE is not met as evidenced by: Based on document review, observation and interview the facility failed to implement policy related to medications in one facility. Findings include: 1. Review of facility policy, Medical, revised 12/7/2017, indicated the following, every staff member removes conditions that are unsafe to patients immediately, and then notifies their supervisor. Act first, communicate second. Such unsafe conditions include: expired drugs or laboratory reagents, improper staff actions, faulty equipment, etc... The Head Nurse oversees that all nursing staff adhere to best practices and standards of care in the handling, packaging, administering and handing out of medication. ...discards all drugs that will expire in the coming month. 2. On observation 4/2/2018, at approximately 3:27 pm, in the medication room, with N1 (Registered Nurse, Assistant Director) the following was observed. 4 vials of diazepam 5mg/ml, 10 ml, 2 expired 9/2017, and 2 expired 12/2017, not included in count. Inside a box marked needles was a plastic bag which contained blue paper taped shut which contained 5 vials of Gentamicin 80 mg/2ml, expired	T 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011128	A. BUILDING: _____ B. WING _____	04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOMEN'S MED GROUP PROFESSIONAL CORPORAT	1201 N ARLINGTON AVE INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 322	Continued From page 10 3/1/2015. 3. Interview on 4/2/2018, at approximately 3:47 pm, with N1 confirmed the above.	T 322		
T 404	410 IAC 26-17-3 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-3(2) The condition of the physical plant and the overall clinic environment must be developed and maintained in such a manner that the safety and well-being of patients is assured as follows: (2) No condition may be created or maintained that may result in a hazard to: (A) patients; (B) authorized visitors; or (C) employees. This RULE is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have appropriate equipment to use a caustic chemical substance according to manufacturer's instructions in 3 instances. Findings include: 1. On 04-02-2018 at approximately 4:35 pm, in the presence of employee #A1, Assistant Director), it was observed in the product of conception processing area a chemical, MetriClean 2, was stored. 2. In interview on the above date and time,	T 404		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011128	A. BUILDING: _____ B. WING _____	04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOMEN'S MED GROUP PROFESSIONAL CORPORAT	1201 N ARLINGTON AVE INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 404	Continued From page 11 employee #A1 indicated the chemical was used when processing product of conception. 3. Review of the label on the bottle of MetriClean 2, a caustic chemical,indicated there were manufacturer's instructions which indicated First Aid Measures: EYES - Flush immediately with water for 20-30 minutes. 4. Review of the OSHA (Occupational and Safety Health Administration) hazard communication program indicated in general standard 1910.151 when necessary, facilities for drenching or flushing the eyes shall be provided within the work area for immediate emergency use. In applying these general terms, OSHA would consider the guidelines set by such sources as American National Standards Institute (ANSI) Z358.1 -1998, Emergency Eyewash and Shower Equipment, which indicated in section 7.4.4, that eyewash facilities are to be located to require no more than 10 seconds to reach but where a strong acid or a caustic chemical is used, the unit should be immediately adjacent to the hazard. 5. On the above-stated date, time, place, and presence of employee #A1, it was observed there was no eyewash facility immediately adjacent to the area where the caustic chemical was used. 6. On 04-02-2018 at approximately 4:40 pm, in the presence of employee #A1, Assistant Director, it was observed in Operating Room 1 there was an electrical outlet on a wall which had a broken plug receptacle. This posed an electrical hazard if an electrical plug was not properly seated in the receptacle. 7. On 04-02-2018 at approximately 4:40 pm, in the presence of employee,#A1, it was observed	T 404		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011128	A. BUILDING: _____ B. WING _____	04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOMEN'S MED GROUP PROFESSIONAL CORPORAT	1201 N ARLINGTON AVE INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 404	Continued From page 12 in Operating Room 1 on another wall, there was an alcohol-based hand sanitizer (ABHS) on the wall directly over an electrical outlet. This posed a fire hazard if the flammable alcohol in the sanitizer was sprayed or dropped into the electrical ignition source.	T 404		